# Improving Pain Care for Returning Troops

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WASHINGTON (AP) - They call it the coming tsunami, veterans returning from Iraq who will suffer chronic pain years from now. Get ready, military doctors are warning pain specialists-- even as they hope that slowly improving battlefield pain control may stem the tide.

The idea: Block the agony faster, and the body's pain network may not go into the overdrive that sets up the injured for lingering trouble long after they're officially healed.

"It's going to take the military to stop thinking of pain as a symptom, a consequence of war," says Lt. Col. Chester "Trip" Buckenmaier III, an acute pain specialist at Walter Reed Army Medical Center who is pushing for that change.

"Pain really is a disease. If you don't manage it early, it leads to serious consequences."

At risk aren't just troops who suffered severe wounds such as loss of a limb, but others with varying types of pain that goes untreated, or undertreated.

Why? "If you don't ask, they don't report" pain, says Dr. Robyn Walker, a psychologist at the James A. Haley Veterans Affairs Hospital in Tampa.

Troops with traumatic brain injuries, a signature of the war, may not be able to express pain adequately. More common is a tough-it-out mentality, she says, a fear that admitting pain might block return to duty _ or hesitancy because they know wounds could have been worse.

Remarkably, Walker says it's not unusual to discover fractures or shrapnel previously missed because a soldier didn't acknowledge continued pain until her office pushed for details.

"Most pain doctors won't see the severely injured. The VA will keep them," says Dr. Michael Clark, chief of chronic pain rehabilitation at the Tampa VA.

But other veterans eventually will seek community care, Clark warned an American Pain Society meeting last week: "This is going to impact you for decades to come."

Doctors have long known that suppressing acute pain aids short-term recovery. But it's also a factor in whether patients develop a long-term misery, chronic pain.

Consider: Injured nerves send distress signals to the brain. If those signals go unabated, the brain can essentially memorize pain and become hypersensitive. An infamous example is the phantom limb pain that often strikes amputees. But less severe injuries can spur chronic pain, too, which in turn is linked to post-traumatic stress disorder, other anxiety disorders, and disability.

At the war's beginning, "we were using Civil War-era pain management, " is Buckenmaier's grim assessment. Morphine was the main option as the wounded were evacuated to Germany on excruciating plane flights. But many were deemed too vulnerable for doses in the air, where nurses could do little if the drug depressed their breathing, he explains.

While morphine is a crucial painkiller, it doesn't actually block pain signals from reaching the brain.

What can? Continuous nerve blocks, developed at civilian hospitals using increasingly portable drug-infusion pumps. Doctors trace the roots of nerves signaling certain pain, such as from arm or leg wounds. They insert tiny catheters that allow drugs to bathe those nerves and block that signal. It requires an anesthesiologist or other specialist trained in nerve anatomy.

Buckenmaier delivered the first battlefield nerve block in October 2003. A rocket-propelled grenade tore out a chunk of a soldier's lower leg; eventually, it would be amputated. But minutes after receiving the nerve block at a field hospital, he said he was pain-free. He sat up and joked with buddies instead of being in the usual post-surgery drug stupor. The infusion pumps lasted through evacuation to Landstuhl, Germany, and on to Walter Reed, including several operations over 16 days.

Hundreds of troops now have received nerve blocks, although Buckenmaier says they're "applied inconsistently" in battlefield hospitals with few acute-pain specialists. Last month, he helped open an acute pain center in Landstuhl to expand pain-control options there.

Does that early care truly prevent chronic pain after such extreme wounds? Buckenmaier and Dr. Rollin Gallagher of the University of Pennsylvania are beginning to track injured troops to find out.

Immediately after the injury isn't the only vulnerable time, and nerve blocks aren't the only solution. A recent Johns Hopkins University study tracked pain after leg trauma and amputations, and found that patients who took narcotic painkillers for three months after leaving the hospital were less likely to develop chronic pain.

Nor is severe trauma the only concern. Clark is seeing lots of chronic knee pain; perhaps jumping out of trucks wearing 60-pound packs is too hard on the joints, especially for older troops.
Then there are those high-powered blasts, where bystanders can walk away seemingly unscathed. Doctors are increasingly concerned that they may suffer nerve damage, perhaps signaled by headaches. Any doctor seeing an Iraq veteran should ask about headaches, Clark told last week's pain meeting.
"The usual course of pain treatment is failure, failure, failure, then go to a pain specialist," laments Pennsylvania's Gallagher. "We want early intervention."

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